

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

HEALTH CARE FINANCING ADMINISTRATION OMB NO. 0938-0193

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION</b>	1. TRANSMITTAL NUMBER:  <b>03-27</b>	2. STATE  <b>Louisiana</b>
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE  <b>July 3, 2003</b>	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

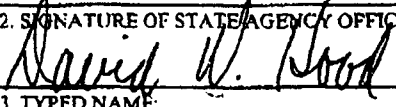
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:  <b>42 CFR 447.272</b>	7. FEDERAL BUDGET IMPACT: a. FFY <u>2003</u> <b>\$6,331.38</b> b. FFY <u>2004</u> <b>\$26,519.77</b>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-A, Item 1, Page 1f Attachment 4.19-B, Item 2a, Page 4</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Same (TN 03-03) New Page</b>

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to utilize the upper payment limit for state government owned or operated hospitals to enhance federal funding in the Medicaid Program**

11. GOVERNOR'S REVIEW (Check One):

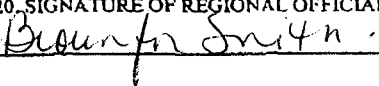
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☒ OTHER, AS SPECIFIED: **The Governor does not review state plan material**☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: <b>State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030</b>
13. TYPED NAME: <b>David W. Hood</b>	
14. TITLE: <b>Secretary</b>	
15. DATE SUBMITTED: <b>September 23, 2003</b>	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: <b>MAY 17 2004</b>
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>JUL - 3 2003</b>	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: <b>Charlene Brown</b>	22. TITLE: <b>Deputy Director, CMSO</b>

23. REMARKS:

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING RATES - IN-PATIENT HOSPITAL CARE

The inpatient routine services costs for Medical Assistance recipients will be determined after the application of the Title XVIII method of apportionment and the calculation will exclude the applicable Title XVIII inpatient routine services charges or patient days, as well as Title XVIII inpatient routine services costs (including any nursing salary cost differential).

6. Supplemental Payment for State Hospitals

A supplemental payment shall be issued to state owned and operated hospitals for inpatient hospital services subject to the payment limits of 42 CFR §447.272. The inpatient upper payment limit for state hospitals will be calculated based on each hospital's latest filed cost report and claims data corresponding with the period to determine the reasonable costs in accordance with Medicare principles of reimbursement.

The supplemental payment calculation shall be the difference between the calculated payments using the Medicare principles of reimbursement less the estimated Medicaid per diem payments (subject to target rate limitations) for each state hospital. This amount shall be trended forward to the mid-point of the current state fiscal year based on the Centers for Medicare and Medicaid Services (CMS) Hospital Market Basket Index for PPS hospitals. This supplemental payment calculation is an annual calculation of which a fourth will be distributed on a quarterly basis. Payments are made at the beginning of the quarter.

Estimated Medicaid payments will be equal to the actual paid amount on a per diem basis plus any other payments that the facility is entitled (e.g. outlier payments, etc.) based on state guidelines. Medicaid DSH payments will be excluded from consideration as required

TN# 03-27  
Supersedes  
TN# 03-03

Approval Date MAY 17 2004

Effective Date JUL - 3 2003

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE OF LOUISIANA

ATTACHMENT 4.19-B  
Item 2a, Page 4

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905(A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN AS DESCRIBED AS FOLLOWS:

**f. Supplemental Payment for State Hospitals**

A supplemental payment shall be issued to state owned and operated hospitals for outpatient hospital services subject to the payment limits of 42 CFR §447.321. The outpatient upper payment limit for state hospitals will be determined using the latest available cost report and corresponding claims data to determine the reasonable costs in accordance with the Medicare principles of reimbursement. The supplemental payment calculation shall be the difference between outpatient costs using the Medicare principles of reimbursement less the Medicaid reimbursement for outpatient services each state hospital. This amount shall be trended forward to the mid-point of the current state fiscal year based on the Centers for Medicare and Medicaid Services (CMS) Hospital Market Basket Index for PPS hospitals. This supplemental payment calculation is an annual calculation of which a fourth will be distributed on a quarterly basis. Payments are made at the beginning of the quarter.

TN# 03-27  
Supersedes  
TN# \_\_\_\_\_

Approval Date MAY 17 2004

Effective Date JUL - 3 2003